ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
SARAH J. JACOBS
Deputy Attorney General
State Bar No. 255899
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2312
Facsimile: (559) 445-5106
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Pervaiz Akhter Chaudhry, M.D.** **7455 N Fresno St., Ste. 301** **Fresno, CA 93720-2481** **Physician's and Surgeon's Certificate No. A 79662,** Respondent.	Case No. 800-2018-045293 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A 79662 to Pervaiz Akhter Chaudhry, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2021, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code, unless otherwise indicated.

4. Section 2227 states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 states, in pertinent part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

[¶] . . . [¶]

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

[¶] . . . [¶]

6. Section 2266 states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FACTUAL ALLEGATIONS

PATIENT A[1]

7. Patient A was an 81-year-old male with a history of diabetes, hypertension and hyperlipidemia.

a) On or about July 14, 2016, Respondent performed an elective coronary artery bypass grafting surgery on Patient A. Patient A received a left internal mammary artery to left anterior descending artery graft, along with saphenous vein grafts to the first and second obtuse marginal branches of the circumflex artery. His right coronary artery was found to be unbypassable. The intra-operative course noted hemodynamic instability requiring multiple vasopressors upon his leaving the operating room.

b) Patient A's post-operative notes showed continued hemodynamic instability and moderate bleeding. Patient A arrived in the Intensive Care Unit (ICU) at approximately 12:40 p.m.

c) At approximately 2:15 p.m., Patient A had an episode of ventricular tachycardia. ICU staff notified Respondent and he requested that they contact another physician. At approximately 2:20 p.m., ICU staff called the other physician, and he arrived at Patient A's bedside by 2:30 p.m. At approximately 3:10 p.m., intra-aortic balloon pump was placed in Patient A's chest and his chest tube output was 560 cubic centimeters (cc) within the last hour and total output since surgery was 750 cc. At approximately 4:05 p.m., blood factors were given to Patient A.

[1] Patient names are redacted to protect their privacy.

d) At approximately 5:00 p.m., Respondent was at Patient A's bedside for treatment. His total chest tube output at 6:00 p.m. was 1200 cc. As Patient A's chest tube continued to drain at approximately 350-360 cc per hour, the other physician was again called at approximately 8:00 p.m. and he arrived at approximately 8:15 p.m. The decision was made to take Patient A back to the operating room for a mediastinal exploration, and Patient A left the ICU at approximately 8:50 p.m.

e) On return to the operating room, Patient A had a cardiac arrest requiring CPR, and he was emergently placed on cardiopulmonary bypass. Patient A had biphasic flow in the vein graft to the second obtuse marginal, and the distal anastomosis was then explored and revised. It was noted that Patient A suffered severe right ventricular failure and was placed on extracorporal membraneous oxygenation (ECMO).

f) On or about the following morning, July 15, 2016, Patient A returned to the operating room for re-exploration. No specific bleeders were identified, and his chest was left open. Patient A did not recover cardiac function and remained in multi-organ failure while dependent on ECMO. Patient A was placed in comfort care on or about July 19, 2016, and died that day.

g) Patient A suffered substantial intraoperative myocardial infarct and was on significant amounts of four inotropic agents. Such a result, in combination with lateral ST elevations and transesophageal of severe right ventricle failure, suggests that further deterioration could be anticipated. It was a simple departure from the standard of care for Respondent to not have inserted an intra-aortic balloon pump during the first surgery in order to attempt to stabilize Patient A prior to leaving the operating room. However, it likely would not have reversed Patient A's outcome.

h) Respondent's medical records of the preoperative history and physical done on the day of the surgery fail to mention specific cardiac catheterization result, echo results, or heart exam. Such records are important to summarize the thought process going into the surgery recommendation.

///

PATIENT B

8. Patient B was a 61-year-old male with a history of end-stage renal disease (ESRD), on dialysis, insulin dependent diabetes mellitus, cirrhosis seizure disorder with possible stroke in the past, and hyperlipid disorder.

a) On or about April 17, 2017, Patient B underwent a cardiac catheterization, and was found to have three-vessel disease. He was then transferred for coronary artery bypass grafting and was seen by Respondent on or about April 18, 2017. Respondent made a medical notation that Patient B was seen, but that the angiograms from the prior hospital were not available for him to review.

b) On or about April 22, 2017, Respondent performed a full history and physical examination of Patient B. Respondent's preoperative history and physical did not mention specific cardiac catheterization results, echo result, or a heart exam. Such documentation is important to summarize the thought process going into the recommendation of heart surgery.

c) On or about April 23, 2017, Respondent performed an off-pump coronary artery bypass surgery. Respondent's operative notations only state that an intra-aortic balloon pump was placed; it does not describe its placement or its indication.

FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

9. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to his provision of services to Patient A and Patient B, as more particularly alleged in paragraphs 7 through 8, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

10. The standard of care is for a preoperative history and physical exam to document the elements that determine the risks and benefits of an operation prior to the operation.

a) Respondent failed to maintain adequate and accurate medical records regarding Patient A because his records were incomplete and failed to document significant

factors that contribute to the risk involved in the surgery performed upon Patient A by Respondent, which is a simple departure from the standard of care.

b) Respondent failed to maintain adequate and accurate medical records regarding Patient B because his records were incomplete and failed to document the indications and performance of the operation he performed, which was a simple departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

11. Respondent Pervaiz Akhter Chaudhry, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts relating to his provision of services to Patient A and Patient B as more particularly alleged in paragraphs 7 through 10, above, which are hereby realleged and incorporated by reference as if fully set forth herein. Additional circumstances are as follows:

12. It is the standard of care for all available options to be exhausted in order for a patient to maintain hemodynamic stability prior to leaving the operating room. Respondent committed a simple departure from the standard of care by not placing an intra-aortic balloon pump to attempt to stabilize Patient A prior to leaving the operating room.

///

///

///

///

///

///

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 79662, issued to Pervaiz Akhter Chaudhry, M.D.;

2. Revoking, suspending or denying approval of Pervaiz Akhter Chaudhry, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Pervaiz Akhter Chaudhry, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: JUN 15 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

FR2021302248
Chaudry Acc with client edits.docx